

MARYLAND HEALTH QUALITY AND COST COUNCIL

Report to the Governor and General Assembly

January 2009

The Honorable Anthony G. Brown, Lieutenant Governor  
State of Maryland

John M. Colmers, Secretary  
Maryland Department of Health and Mental Hygiene

# MARYLAND HEALTH QUALITY AND COST COUNCIL

## MEMBERS AND AFFILIATIONS

Chair: Anthony G. Brown, Lieutenant Governor, State of Maryland

Vice Chair: John M. Colmers, Secretary, Department of Health and Mental Hygiene

### Appointees:

Jill A. Berger, M.A.S.

Vice President, Health and Welfare Plans, Marriott International

Debbie Chang, M.P.H.

Senior Vice President and Executive Director,  
Nemours Health and Prevention Services

James S. Chesley, Jr., M.D.

Practicing Gastroenterologist

Richard "Chip" Davis, Ph.D.

Vice President for Innovation and Patient Safety, Johns Hopkins Medicine (JHM)  
Executive Director, JHM Center for Innovation in Quality Patient Care  
Executive Director, JHM East Baltimore Ambulatory Operations

Barbara Epke, M.P.H., M.S.W., M.A.

Vice President, LifeBridge Health System

Thomas A. LaVeist, Ph.D.

William C. and Nancy F. Richardson Professor in Health Policy,  
Johns Hopkins Bloomberg School of Public Health  
Director, Center for Health Disparities Solutions

Roger Merrill, M.D.

Chief Medical Officer, Perdue Farms Incorporated

Peggy O'Kane, M.H.S.

President, National Committee for Quality Assurance (NCQA)

E. Albert Reece, M.D., Ph.D., M.B.A.

Vice President for Medical Affairs, University of Maryland  
Dean, University of Maryland School of Medicine

Christine M. Stefanides, R.N., F.A.C.H.E.

President and CEO, Civista Health, Inc. and Civista Medical Center, Inc.

Reed Tuckson, M.D.

Executive Vice President and Chief of Medical Affairs,  
United Health Group

Kathleen White, Ph.D., R.N., C.N.A.A., B.C.  
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# MARYLAND HEALTH QUALITY & COST COUNCIL

## 2008 REPORT

### I INTRODUCTION AND BACKGROUND

- A. Establishment and Purpose of the Council
- B. HB 1395: Chronic Care Management Plan
- C. Council Membership

### II 2008 ACTIVITIES

- A. Maryland Baseline
- B. Other State's Efforts to Improve Quality and Contain Costs
- C. Existing Maryland Initiatives

### III WORKPLAN & FUTURE ACTIVITIES

- A. Focus of Workgroups
  1. Chronic Care Workgroup Focus
  2. Primary Care/Medical Home Workgroup Focus
  3. Evidence-based Practice Workgroup Focus
- B. Workgroup Goals and Processes
- C. Timeline for Future Activities

### IV APPENDICES

- A. Council Members by Workgroup

## I. INTRODUCTION AND BACKGROUND

### COUNCIL'S ESTABLISHMENT AND PURPOSE

In October 2007, Governor Martin O'Malley established the Maryland Health Quality and Cost Council (HQCC).

The Council is tasked with providing the leadership, innovation, and coordination of multiple stakeholders within our health system—payers, institutional providers, physicians, government, patients, and citizens—in an effort to improve the health of Maryland's citizens, maximize the quality of health care services, and contain health care costs.

The Governor's executive order suggests the promotion of wellness, the adoption of advancements in disease prevention and chronic care management, the increased diffusion of health information technology (HIT), and the development of a chronic care plan as important strategies for the Council to consider.

To further define and guide its work, the Council has articulated the vision and mission statements listed below.

**Vision Statement:** The State of Maryland is a demonstrated national leader in the implementation of innovative, effective cost containment strategies and the attainment of health and high quality health care. The State's efforts are guided by a commitment to ensuring that care is safe, effective, patient-centered, timely, efficient, equitable, integrated, and affordable.

**Mission Statement:** To maximize the health of the citizens of Maryland through strategic planning, coordination of public and private resources, and evaluation that leads to: effective, appropriate, and efficient policies; health promotion and disease prevention initiatives; high quality care delivery; and reductions in disparities in healthcare outcomes.

### HB 1395: CHRONIC CARE MANAGEMENT PLAN

During the 2008 legislative session, the Maryland General Assembly elaborated on the development of the Council's chronic care plan, noting that it should include how best to disseminate to health care providers information on evidence-based treatment and prevention practices for chronic conditions. Recognizing that it takes between 15 and 17 years before evidence typically is translated into widespread clinical practice, the legislation suggests that the Council consult with multiple Maryland stakeholders and consider "best-practices" both within Maryland and externally when developing the plan. Moreover, the legislation requires that the Council coordinate with appropriate groups to collect data to evaluate the clinical, social, and economic impact of chronic care and prevention activities in different parts of the State.

To create and execute the chronic care plan, which is due on December 1, 2009, the General Assembly has authorized the Council to accept funds from external sources.

## **COUNCIL MEMBERSHIP**

In addition to the Lieutenant Governor and the Health Secretary, who serve as the Council's Chair and Vice Chair respectively, the Council consists of twelve other members, each appointed by the Governor for a three-year term. In accordance with the executive order, the Council has at least one representative each drawn from the ranks of the health insurance industry, employers, health care providers, health care consumers, and health care quality experts.

Three of the Council's members represent provider organizations. James Chesley, Jr., M.D. is a practicing gastroenterologist with offices in Prince George's County. Barbara Epke is Vice President at LifeBridge Health System, which consists largely of Sinai Hospital, Northwest Hospital, Levindale Hebrew Geriatric Center and Hospital, and the Jewish Convalescent & Nursing Home, in Baltimore City and Baltimore County. Christine Stefanides is President and CEO of Civista Health, Inc. and Civista Medical Center, Inc., a hospital and clinic network serving the citizens of Charles County and Southern Maryland.

Two of the Council's members are drawn from the ranks of the State's teaching institutions and represent, respectively, medicine and nursing. E. Albert Reece, M.D., Ph.D., M.B.A. is the Dean of the University of Maryland School of Medicine, located in Baltimore City, and also Vice President of Medical Affairs for the University of Maryland system. Kathleen White, Ph.D., R.N. is an Associate Professor and Director of the Masters Program at the Johns Hopkins School of Nursing, also in Baltimore City.

Two Council members represent large employer groups. Jill Berger is Vice President for Health and Welfare Plan Management and Design for Marriott International, headquartered in Montgomery County, and Roger Merrill, M.D. is Chief Medical Officer for Perdue Farms Incorporated, based in Wicomico County on the Eastern Shore.

Reed Tuckson, M.D., and Debbie Chang, M.P.H., represent, respectively, the voices of health insurers and consumers on the Council. Dr. Tuckson serves as Executive Vice President and Chief of Medical Affairs for UnitedHealth Group, based in Minnetonka, Minnesota. Ms. Chang, who is a Maryland resident, is the Senior Vice President and Executive Director of Nemours Health and Prevention Services in Wilmington, Delaware.

Finally, three of the Council's members are nationally recognized experts on three different facets of health care quality, namely managed care, inpatient care, and health disparities. Peggy O'Kane, who is a Maryland resident, is the President of the National Committee for Quality Assurance (NCQA), a leading developer of quality and performance measures for managed care organizations located in Washington, DC. Richard (Chip) Davis, Ph.D., is the Vice President for Innovation and Patient Safety at The Johns Hopkins University School of Medicine in Baltimore City, and Thomas LaVeist, Ph.D. directs the Center for Health Disparities Solutions at The Johns Hopkins Bloomberg School of Public Health, also in Baltimore City.

## II. 2008 ACTIVITIES

In accordance with Executive Order 01.01.2007.24 and HB 1395, the Council plans to submit a comprehensive strategic plan for improving the health of Marylanders to the Governor and General Assembly on December 1, 2009. The plan will provide a roadmap for realizing the Council's mission and vision.

As a first step in developing this plan, the Council embarked on an effort, which will continue in 2009, to understand precisely where the State stands relative to its peers—and why—on key indicators of population health, health care quality, and health system costs.

In addition, as part of this effort, the Council began to develop a detailed inventory of existing health improvement initiatives and activities in the state undertaken by both public sector agencies and private sector groups, including insurance carriers, employers, and hospitals, among others. The Council believes that existing initiatives and relationships are likely to serve as a foundation on which to build future efforts to improve population health and the quality of the health care system.

Finally, the Council also sought to better understand the health care quality improvement and cost containment initiatives that are being considered and undertaken by other states, as well as international bodies focused on quality of care. The goal of these activities is to note those elements, policies, and practices that have been most successful and thus might serve as a guide or blueprint for the development of the Council's strategic plan.

What follows is a snapshot of some of these activities.

### MARYLAND BASELINE

Maryland is home to a number of world-renowned hospitals and medical and public health teaching institutions. However, by most objective measures, when compared to other states, it is merely average in terms of the quality of its health care system, the health of its population, and the cost of its care.

According to the Commonwealth Fund's State Scorecard on Health System Performance, Maryland ranks only slightly above the middle on an aggregate indicator of health system performance<sup>1</sup>. Although the state performed somewhat better on measures of health care access, equity, and quality than most states, Maryland was below average on key indicators of avoidable hospitalizations and costs of care. On measures of mortality amenable to health care as well as health-related limitations faced by adults, Maryland falls in the lowest quartile.

The Agency for Health Care Quality and Research's (AHRQ) National Healthcare Quality Report in 2007, paints a similarly lackluster picture of the state's health system performance<sup>2</sup>.

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<sup>1</sup> Commonwealth Fund Commission on a High Performance Health System. (2007). *Aiming Higher: Results from a State Scorecard on Health System Performance*. New York: The Commonwealth Fund.

<sup>2</sup> Agency for Healthcare Quality and Research and Quality. (2007). *National Healthcare Quality Report, 2007* (Publication no. 80-0040. Retrieved January 20, 2009, from AHRQ Website: <http://www.ahrq.gov/qual/nhqr07/nhqr07.pdf>.

AHRQ characterized Maryland's performance on chronic and acute care measures as average, while rating its performance on preventive care measures as weak. The agency noted greater variability in the State's performance across different settings of care, however: performance on home health care measures was considered strong; performance on ambulatory care measures was noted as average; while performance on hospital and nursing home measures was considered weak. With respect to disease specific conditions and key populations, AHRQ called the State's performance on diabetes and heart disease measures as average compared to that of other states. Performance on maternal and child health measures and cancer care measures was noted as weak, while performance on respiratory diseases care measures was classified as very weak.

Furthermore, United Health Foundation, which compiles an annual ranking of the health of state populations based on personal behaviors, community and environmental factors, public and health policies, as well as clinical care, also placed Maryland squarely in the middle relative to its peers based on a weighted ranking of these elements<sup>3</sup>.

Moving forward, the Council's Workgroups (described in a later section) will seek to better understand why the State's performance is merely "average" across this spate of health system performance measures and population health indicators. Such findings will play a key role in helping the Council determine Workgroup focus areas and prioritize Workgroup strategies.

## **OTHER STATES' EFFORTS TO IMPROVE QUALITY AND CONTAIN COSTS**

Some of the most successful states in terms of both population health and higher performing health systems include Vermont, New Hampshire, and Maine in New England, Connecticut in the Mid-Atlantic, and Hawaii in the West.

At its first meeting in May 2008, the Council sought to explore publically-led efforts by these and other states to improve population health, raise health care quality, and reduce health system costs.

The Council's Workgroups, which are described in detail in the section that follows, will also delve into the activities of other state "quality councils" as part of their work in 2009.

Many states are seeking ways to promote primary care and care coordination, particularly around prevalent chronic conditions such as diabetes and cardiovascular disease. Several states, including Vermont, Maine, Massachusetts, and Pennsylvania, are looking at ways to pilot the Wagner Chronic Care Model as part of a state-sponsored and financed medical home initiative.

In December 2008, Council members were briefed by an aide to Pennsylvania's Chronic Care Management, Reimbursement and Cost Reduction Commission on how that state is implementing a voluntary medical home pilot program funded largely through user fees on managed care companies.

Additional state efforts to improve quality include initiatives in Minnesota and Massachusetts to

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<sup>3</sup> United Health Foundation. (2008). *America's Health Rankings: A Call to Action for Individuals & Their Communities, 2008 Edition*. Retrieved January 20, 2009 from United Health Foundation Website: <http://www.americashealthrankings.org/2008/pdfs/2008.pdf>.



systematize the reporting of quality measures across different payers within the state. Massachusetts is also exploring ways to reform the existing volume-based payment system, which typically creates incentives for more treatment at the expense of preventive services, such as primary care and behavior modification counseling.

## EXISTING MARYLAND INITIATIVES

At its September 2008 meeting, State government staff briefed the Council on key public sector initiatives currently in place in Maryland's Medicaid program, the State's hospital sector, and the State's public health apparatus.

For example, the State's Deputy Secretary for Health Care Financing discussed the use of the Healthcare Effectiveness Data and Information Set (HEDIS) to assess the performance of HealthChoice managed care organizations relative to one another and compared to national Medicaid benchmarks.

In the State's hospital sector, the Deputy Director of the Health Services Cost Review Commission (HSCRC) discussed the commission's Quality-based Reimbursement Initiative (QBR), which will go into effect in July 2009. The effort will require hospitals to publicly report quality measures, including many of the same measures used in Medicare's Hospital Compare program. It will also tie hospital compensation for all patients—not just those participating in Medicare—to the attainment of select quality benchmarks and individual hospital performance improvement. The effort is similar to Medicare's Premier Hospital Quality Incentive Demonstration Project.

Also working to improve the quality of care provided in Maryland's hospitals is the Maryland Patient Safety Center. The Center, which opened in 2004, tracks adverse events and conducts training, education, research, and special projects for individual hospitals and health systems. Recent training collaborations have included efforts to reduce methicillin-resistant staphylococcus aureus (MRSA) infection, improve efficiency and patient flow in emergency departments, and reduce the number of adverse events associated with childbirth.

With respect to public health, Family Health Administration staff described current initiatives to improve vaccine coverage in Maryland. They also addressed data collection and analytic efforts underway to more accurately assess the incidence and prevalence of chronic disease both geographically and within key subgroups in Maryland. Such efforts will allow the state to better measure the impact of the Council's efforts over time.

At its December 2008 meeting, the Council turned its attention to some of the more innovative efforts currently employed by Maryland's private sector to improve health and health care quality. These included a medical home pilot program under development by CareFirst BlueCross BlueShield, one of the state's largest insurance carriers; a pharmaceutical value-based purchasing program recently initiated by Marriott International; and computerized order entry (COE) system, robotics, and other ways to mechanize the ordering and administration of medications in an effort to reduce medication errors to near zero in the hospital setting.

In 2009, the Council and its Workgroups will look closely at these and other activities underway in the State to determine the feasibility of building on or expanding them in order to improve the health of Marylanders, improve the health system, and reduce costs.

### III. WORK PLAN & FUTURE ACTIVITIES

At present, the Council's primary task is to create a comprehensive strategic plan, due on December 1, 2009. The plan will detail how to improve population health, improve quality of care, and contain health care costs within Maryland. This is, however, a broad and complicated endeavor. To make the task more manageable, the Council decided to narrow the topics on which it would focus, at least in the near term. Accordingly, the Council created three Workgroups whose broad charges are described below. Each Workgroup consists of several Council members as well as individuals from the private sector, academia, and government with expertise related to the workgroup's charge. A list of Council members participating in each Workgroup can be found in Appendix A; the Workgroups are still in the process of soliciting non-Council members.

#### FOCUS OF WORKGROUPS

##### **Chronic Care Workgroup**

The Chronic Care Workgroup's activities will focus largely on health promotion and disease prevention activities at a population level. The group will single out those chronic conditions responsible for considerable morbidity and mortality in the State for the bulk of its recommendations and initiatives. The conditions selected by the Workgroup must be amenable to improvement through both a combination of public health initiatives and campaigns as well as improved clinical care. Outcomes or processes for the selected conditions will also be easily measurable. In other words, clearly defined quality and performance measures will exist for these conditions, permitting the Council to track the State's progress in meeting the objectives of its strategic plan.

The group will work closely with the Primary Care/ Medical Home Workgroup, as the activities of both groups are highly synergistic. While the Primary Care/ Medical Home group will focus on ways to reform clinical care, the Chronic Care Workgroup will compliment these clinical activities by focusing on a series of supportive strategies and initiatives at the community level. Such activities will involve behavioral modification, community education, changes in urban planning, social marketing campaigns, and greater involvement by local and community groups in wellness, health promotion, and prevention activities.

The Workgroup will conduct its first meeting (by conference call) on January 30, 2009.

##### **Evidence-based Practices ("Low-Hanging Fruit") Workgroup**

The Council thought it expedient to create a group to focus on the widespread implementation of a limited number of mainly hospital-based practices that have been shown to improve care quality and could be instituted on a large scale relatively quickly. The Council has termed such practices "low-hanging fruit" because there is little or no debate about their effectiveness. Moreover, groups such as the Institute for Healthcare Improvement (IHI) in Massachusetts, among others, have well-developed templates allowing hospital boards and staff to quickly roll-out and sustain such initiatives.

The Workgroup will recommend the implementation of several highly effective inpatient practices to the Council. In addition, the Workgroup's recommendations will include strategies and timelines for their implementation.

The Workgroup will conduct its first meeting (by conference call) on January 30, 2009.

### **Primary Care/ Medical Home Workgroup**

The Primary Care/ Medical Home Workgroup will explore strategies to create and finance comprehensive medical home models in Maryland. The Workgroup will build on the recommendations of the Maryland Task Force on Health Care Access and Reimbursement (SB 107). The Task Force, which issued a draft of its final report in December 2008, suggests that the Council "[c]reate a uniform statewide approach to assist physicians' practices in establishing medical homes by:

- Promoting the formation of medical homes based on the ACP's [American College of Physician's] principles for medical homes;
- Creating multi-stakeholder coalitions composed of payers, providers, and purchasers that will develop common reimbursement and performance incentives for medical homes;
- Identifying equitable sources of start-up funding so that initial costs can be shared among providers, payers, and purchasers commensurate with the longer-term benefits; and
- Mobilizing the multi-stakeholder coalitions to compete for medical home demonstrations offered by CMS and various nonprofit organizations."

Building on the Task Force's recommendations, the experiences of other states, and information from CareFirst's medical home pilot program in Maryland, the Workgroup will articulate strategies to create and finance a medical home model in Maryland.

The Primary Care/ Medical Home Workgroup will work closely with the Chronic Care Workgroup to ensure that efforts at the community and clinical levels are complementary.

The Workgroup will hold its first meeting at the end of February or in early March.

### **WORKGROUP GOALS AND PROCESSES**

To create a comprehensive strategic plan, due on December 1, 2009, to improve population health, improve quality of care, and contain health care costs, the Workgroups will meet monthly. They will be responsible for executing the activities listed below for their focus areas and bringing their recommendations to the Council for approval at quarterly meetings. In brief, each Workgroup will be tasked with:

- Narrowing its focus to a handful of key areas;
- Determining strategies to be included in the Council's strategic plan;
- Articulating measures, timelines, estimated costs, and estimated health benefits associated with each strategy;

- Addressing proposed legislation and regulatory changes necessary to accomplish proposed strategies; and
- Determining workgroup activities necessary to monitor execution of the strategic plan in 2010 and beyond.

As part of its deliberations when selecting and elaborating on strategies, each Workgroup will consider ways to ameliorate disparities and expand the use of health information technology. In addition, each Workgroup will thoroughly consider the effect of its proposed strategies on stakeholder groups, such as payers, providers, and patients or consumers, before presenting ideas to the full Council.

## **TIMELINE FOR FUTURE ACTIVITIES**

In order to produce a strategic plan by December 2009, the Council will strive to adhere to the following timetable:

### **March 2009**

- Discuss Workgroup focus areas, goals, and non-Council membership
- Preliminary discussion on workgroup strategies

### **June 2009**

- Discussion and approval of Workgroups' proposed strategies

### **September 2009**

- Finalize Workgroups' strategies, associated measures, estimated costs, estimated benefits
- Discuss legislative and/or regulatory agenda required to implement strategies, measures, and/or costs

### **November 2009**

- Approve final report

### **December 2009**

- Discuss Council's next steps/monitoring role
- Discuss work plan for Council activities moving forward

## IV. APPENDICES

### APPENDIX A: COUNCIL MEMBERS BY WORKGROUP

#### **Chronic Care Workgroup**

##### Council Members

Jill Berger  
Debbie Chang  
James Chesley  
Roger Merrill  
Peggy O’Kane  
E. Albert Reece  
Reed Tuckson

##### Staff

Fran Phillips (Chair – Secretary’s Designee)  
Audrey Regan  
Maria Prince

#### **Evidence-based Practices (“Low-Hanging Fruit”)**

##### Council Members

Jill Berger  
James Chesley  
Chip Davis (Chair)  
Barbara Epke  
Kathi White

##### Staff

Mary Mussman  
Gwen Winston

#### **Primary Care/ Medical Home Workgroup**

##### Council Members

Chip Davis  
Barbara Epke  
Roger Merrill  
Peggy O’Kane  
Chris Stefanides  
Kathi White